

**CHAPTER HFS 37 APPENDIX A
INFORMATION FOR FOSTER PARENTS
FACE SHEET**

Date of Placement: ___ / ___ / ___

Child's Name: _____	Nickname(s): _____
DOB: ___ / ___ / ___	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
SS#: _____	
Cultural Identification (as indicated by child if old enough): _____	
Height: _____	Weight: _____ lbs.
Religious Preference (of child or family): _____	
Physical Characteristics (e.g., scars, tattoos, birthmarks, discolorations): _____	

Child's Social Worker With Whom Foster Parent Will Have Contact:	
Name: _____	Title: _____
Agency: _____	
Agency Secondary Contact (if social worker not available):	
Telephone: Regular Hours: () _____	
After Hours: () _____	

Reason(s) for Placement	
<input type="checkbox"/> Delinquent Act(s) <input type="checkbox"/> Assaultive <input type="checkbox"/> Non-Assaultive	Nature of Offense(s): _____
<input type="checkbox"/> CHIPS, other than CAN	Type of CHIPS: _____
<input type="checkbox"/> CAN <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Neglect	Relationship of Alleged Perpetrator(s) Does the child exhibit any inappropriate sexual behaviors? _____
<input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Handicap <input type="checkbox"/> AODA <input type="checkbox"/> Emotional Disturbance (note related behaviors, e.g., fire starter) <input type="checkbox"/> Learning Disability	

This is a: <input type="checkbox"/> Voluntary Placement <input type="checkbox"/> Court-ordered Placement
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Medical Assistance #: _____

Insurance Company (if any): Name _____
Telephone: () _____

Policy #: _____ Group #: _____

Physician: _____ Type: _____

Address: _____
Telephone: () _____

Dentist: _____

Address: _____
Telephone: () _____

Other Health Specialists/Therapists

Name: _____ Telephone: () _____
Specialty: _____

Name: _____ Telephone: () _____
Specialty: _____

Preferred Hospital: _____
(Note: Use of hospital may be dictated by insurance company/plan)

Is foster parent expected to participate in therapy with the child? Yes No

Name of Child's _____ Birth Mother:
 _____ Stepmother:
 (Check most appropriate one) Adoptive mother:
 Address: _____
 Telephone: () _____

Name of Child's _____ Birth Father:
 _____ Stepfather:
 (Check most appropriate one) Adoptive father:
 Address: _____
 Telephone: () _____

Child's Siblings:

Name: _____ DOB: / / Phone: () _____
 At home Out of home (where: _____)

Name: _____ DOB: / / Phone: () _____
 At home Out of home (where: _____)

Name: _____ DOB: / / Phone: () _____
 At home Out of home (where: _____)

Significant Extended Family Members (Name, Phone and Relationship):

Legal Custodian: _____
 Relationship: _____
 Address: _____ Phone: () _____

GAL*/Legal Counsel: _____
 Address: _____
 Telephone: () _____

*Guardian ad litem

Significant individuals who may be having contact with the child:

<u>Name</u>	<u>Phone</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Individuals whose contact with the child is forbidden or restricted (e.g., supervised visitation)

<u>Name</u>	<u>Relationship</u>	<u>Type of Restriction</u>	<u>Rationale (e.g., court order, parents' wishes)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Should you have any questions about contacts, please call the child's social worker.)

Previous Placements (If no court order prohibiting release of name of previous foster home placement(s))

<u>Type (FH, GH, RCC/CCI, hospital, etc.)</u>	<u>Name</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Attending or Will Attend: _____

Telephone: (____) _____ Grade: _____

Is child enrolled in a special education program? Yes No

If yes, what type: _____

Contact Person: _____

Day Care or Respite Provider(s)

_____ Phone: (____) _____

_____ Phone: (____) _____

Does the child have specific hobbies or interests? Does the child have special abilities/talents (e.g., music, art, athletics)? Does the child prefer group or solitary activities?

Does the child have preferences that the foster parent may want to know about (e.g., favorite foods, clothing, toys, music)?

Placing agency has given the foster parent:

<input type="checkbox"/> Birth certificate (copy), if available	<input type="checkbox"/> Medical records/summary	* <input type="checkbox"/> Social history/summary
* <input type="checkbox"/> Court order	<input type="checkbox"/> Permission to operate hazardous machines	<input type="checkbox"/> Social Security Card
* <input type="checkbox"/> Court report/summary	<input type="checkbox"/> Placement Agreement	* <input type="checkbox"/> Summary of social/psychiatric evaluations
* <input type="checkbox"/> Dental records/summary	* <input type="checkbox"/> School academic records/summary	<input type="checkbox"/> Summary of mental health treatment
<input type="checkbox"/> Information on child's specific diagnosis and/or disability	<input type="checkbox"/> School and community activity permissions	
<input type="checkbox"/> MA card	<input type="checkbox"/> Signed medical release for emergency health care	

* Summary is requested to ensure that materials (e.g., psychological assessments) can be interpreted by foster parents. Primary source documents can be provided if useful for clarification.

**CHAPTER HFS 37 APPENDIX B
INFORMATION FOR FOSTER PARENTS
CHECKLIST**

		Yes	No	NK *	If "Yes", please comment
1.	Previous hospitalizations a. Was anesthesia used? b. Problems with anesthesia?				
2.	Previous serious illnesses or injuries				
3.	Has child had any other medical tests (e.g., CAT Scan, EEG, MRI)?				
4.	Taking any medication including birth control pills or the use of birth control devices which require a prescription or other involvement of a physician? (If "Yes", name of medication, dosage, reason, prescription or over the counter, how given, by whom, who prescribed).				
5.	Immunizations (Indicate date(s))				Date(s)
	DPT (infants)(Diphtheria, Pertussis, Tetanus)				
	Polio (type: TOPV-Oral or IPV-Injectable)				
	MMR (Measles, Mumps, Rubella)				
	Flu				
	Pneumonia				
	Hepatitis B				
6.	Significant biological family medical history: (e.g., cancer, heart problems)				
7.	Medical needs				
	Apnea monitor				
	Gastrostomy				
	Tracheotomy				
	Ventilator				
	Heart monitor				
	Other (specify)				
8.	Degenerative disorder				
9.	Allergies, including animals, insect bites/stings, soap, wool, food, drugs, milk. (If "Yes", to what, symptoms, treatment)				
10.	Child has or ever had the following: (If yes, date child had it)				Date(s)
	7-day Measles				
	3-day German Measles				
	Chicken Pox				
	Rubella				
	Mumps				
	Whooping Cough				
	Scarlet Fever				

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Strep Throat				
Impetigo				
Lice				
Worms				
Sexually Transmitted Disease				
Hepatitis B				
Polio				
Pneumonia				
Mononucleosis				
Scabies				
Other				
11. Current dental problems				
Braces or retainers?				
Bridges or dentures?				
Last dental exam date? _____				
12. Appetite above or below normal				
Balanced diet				
Unusual eating patterns/habits (e.g., large sugar intake, no vegetables)				
13. Abdominal Concerns				
Has had an ulcer or heartburn				
Child regularly uses Tums or other antacid				
Frequent nausea or vomiting				
Child drinks caffeinated coffee or cola. How much per day?				
Has had "yellow jaundice" or liver disease				
Gets abdominal pain				
Child uses laxatives. How often?				
Becomes constipated or gets diarrhea				
Has had blood in stool recently				
Special diet needs (religious, medical, philosophical, vitamin/mineral supplements, etc.)				
14. Anorexia/bulimia/other eating disorders. Ever had treatment?				
15. Headaches				
Migraine				
16. Coordination or balance problems/dizziness				
Has had serious head injury or loss of consciousness				

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Numbness or loss of strength in hand, arm or leg				
Any trouble with swallowing or speaking				
17. Has had a seizure				
Has had epilepsy				
Type and frequency of seizures				
How to respond				
Controlled or uncontrolled				
Ever hospitalized for seizures				
Ongoing medicines for seizures				
18. Does child wear glasses? If yes, for how long?				
Last eye exam (date, Dr.'s name)				
Blurred or double vision				
Contact lenses				
19. Has hearing problem				
Ringing in ears				
Discharge or infection in ears				
Tube(s) in ears				
20. Blocking of nose, discharge, post-nasal drip				
Nose bleeds				
Persistent hoarseness				
21. Treatment for skin trouble, rashes, hives, acne, or breaking out				
22. Has had bursitis, sprain or dislocation of bone or joint				
Cramps or pain in legs				
Backaches				
Arthritis				
23. Thyroid problems				
24. Child has had test for AIDS/HIV (If yes, date: _____)				Results:
25. Child has had test for Hepatitis (If yes, (date: _____)				Results:
26. Chest pain or discomfort/heart concerns				
Asthma or wheezing				
Cough, phlegm, bronchitis				
Has coughed up blood				
Smoke? If yes, how long? How much?				
TB skin test. If yes, when? Results?				
Heart trouble				

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Rheumatic Fever				
Has had electrocardiogram (EKG)				
Has had chest X-ray. If yes, when was last one?				
Heart murmur				
High or low blood pressure. Last check up?				
Irregular heart beat				
Shortage of breath				
Swollen ankles				
How many pillows does child sleep on?				
27. Urinary or prostate problems/Gall bladder				
Incontinence, urine or fecal				
Bleeding or burning when urinating				
Abnormally frequent urination				
Has had kidney or gall bladder stone				
28. Anemia				
29. Blood problems				
30. Cancer, leukemia, or other malignancy				
31. History of abusing or not taking prescribed medications				
32. Alcohol use or abuse				
33. Other drug use or abuse				
AODA treatment				
34. Is child menstruating?				
Child understands menstruation				
Child's periods are normal				
Excessive cramping or pain				
PMS symptoms				
Medication for cramps. If yes, what medication?				
Bleeding or discharge other than when menstruating				
Has had a "yeast" infection				
Has had a "Pap" test. If yes, when? Why?				
Abnormal results?				
35. Child has physical or developmental disabilities				
If yes, what type of disability?				
Autism				
Blindness				
Cerebral Palsy				

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Deafness				
Dyslexia				
Emotional Disturbance				
Epilepsy				
Fetal Alcohol Effect				
Fetal Alcohol Syndrome				
Mental Retardation				
Muscular Dystrophy				
Neurological Impairment				
Physical Impairment				
Other (specify):				
Restrictions on Activities (e.g., lifting, driving, riding bikes)				
Special equipment (e.g., cane, walker, wheelchair)				
36. Considering the age of the child, his/her abilities are not appropriate for:				
Bathing				
Feeding				
Toileting				
Dressing				
Learning				
Receptive Language				
Mobility				
Danger Awareness				
Social/Emotional Functioning				
Capacity for Independent Living				
Other (specify):				
37. Limitations in verbal skills. (If yes, also check a or b below)				
a. Child is non-verbal				
b. Child has very limited verbal skills				
38. History of behavioral or emotional problems				
39. History of treatment for behavioral or emotional problems at a clinic or hospital				
40. Someone in child's immediate family has been treated or hospitalized for emotional or mental health problems. (If yes, also check below)				
Depression				
Anxiety				
Mood swings				

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Suicide attempts				
AODA				
Mental Health				
41. Has the child ever:				
Felt hopeless or depressed				
Had unexplained crying spells				
Planned or attempted suicide				
Had peculiar or bizarre thoughts				
Had trouble eating or sleeping (either too much or too little)				
Had an excess of energy or activity				
Felt like hurting him/her self				
Displayed reckless or dangerous behavior				
Heard things no one else around him/her heard				
Shown inappropriate emotions (reactions that didn't make sense in the situation).				
Assaulted anyone physically (if yes, who, how recently, and how severely).				
Assaulted anyone sexually (if yes, who, how recently, and how severely).				
Assaulted or abused animals				
42. Child has had any of the following problems at home or in the community.				
Withdrawing socially (doesn't want to be around other people)				
Lying or stealing				
Arguing or fighting with peers or siblings				
Clinging excessively to a parent, teacher or other person				
Problems with police				
Setting fires				
Refusing to follow instructions from parents or obey house rules, etc.				
43. Child ran away in past. (If yes, answer below)				
For how long?				
From where did child run?				
Where did child go?				
How was child returned? (Voluntarily, law enforcement, social worker?)				
Why did child run?				
Did/does child run alone or with others?				
44. Child has had any of the following problems at school				
Poor grades				

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Difficulty making friends				
Suspensions from school				
Fighting or arguing with peers or teachers				
Frequent lying or stealing				
Frequent truancy (including cutting classes)				
45. Child has trouble sleeping. If yes, answer below:				
Child takes sleeping pills. If yes, how often?				
General sleeping pattern (sleep alone, cold or warm room, lights on or off, door open or closed, usual hours of sleep, naps, sleep with toy, pajamas, sleep walk, wake during night, etc.) (Circle appropriate description or describe:				
46. Child has fears/phobias. If yes, answer below:				
Darkness				
Animals				
Cars				
Loud noises				
Heights				
Water (e.g., swimming pools, baths, lakes)				
Weather (e.g., wind, thunder, storms)				
Other (specify)				
47. Child has a history of making abuse allegations against care providers				

*NK=Not Known At This Time